Payment/Delivery Reform Work Group
Monday February 6, 2012
United Health Care
8:00am

Attendees: Gus Mannochia, Tilak Verma, Al Kurose, David Keller, Richard Langseth, Paul Block, Bill Hollingshead, Craig O'Connor, Mike Souza, Peter Asen, Al Charbonneau, Steve DeToy, Vivian Weissman, Rob Kalaskowski, Rebecca Kislak, Dominic Delmonico, Stacy Paterno, Patrice Cooper

I. Call to Order: Lindsay McAllister, Health Policy Director for the Lt. Governor's Office called the meeting to order at 8:00am. Welcomed the group.

II. Jenny Hayhurst, United gave a presentation on United's payment reform strategy and delivery system strategy going forward.
   a. Presentation?
   b. Developing a modular set of payment models to align w a providers risk readiness
   c. Drive innovation
   d. Take a collaborative approach as move down the risk continuum.
   e. Value-Based Contracting
   f. Question: Do you have contracts across the country that incorporate all of these constructs of value based purchasing? A. Yes we do, nationally 12% of United's health care services as a whole is paid out through one of these contracts.
      i. Q. 12% including hospitalization? Yes, that is correct. Entire contract as part of a vbc.
   g. Patient-centered Medical Home (21 different PCMH initiatives across 13 states)
   h. Performance-based contracting – the PBC model incorporates annual performance-based, value-driven adjustments into physician and hospital contracts
      i. Measure where United is capturing the cost per lab session, and there is an effort to minimize cost. If is reduced to a certain metric there is an incentive for that.
      ii. Contracts related to admissions and ER utilization challenges? Some challenge on provider readiness, group will really want to feel they can have impact on those measures and sometimes there is provider hesitation. Collectively we are starting out with those that are more fundamental, but then work into those which are more complex that will help us all move forward. Generally we would like to enter into PBC contracts based on practices.
   i. United Healthcare Innovation in RI

i. Q. What will need review? A. Some hospital services, radiology and cardiology services.
ii. Is prior authorization going to be layered on top of the advanced notification? A. Prior authorization will replace notification.
iii. Is one of the tools designed to help practices know real time deductible information? A. On the provider portal that information is available.
iv. Large employers, generally self funded, may say your co-pay is waived if you

j. Questions
i. In terms of the navigate plan you mentioned, is that a plan for insurers who offer insurance? It is for those with full insurance
ii. There was an actuarial evaluation done, and there is a price differential in the product, is expected to be a more cost effective product
iii. In the areas around the country that have ____, provider groups that have total cost of care, how is the balance struck between total cost of care and confidentiality around hospital contracts. How working out nationally? A. Aware in CA we do capitated agreements, information is shared, we have to help the providers get information.
iv. Hospitalist, frequently the primary care provider doesn't have connection with the patient and the hospital – that is why we discussed the risk continuum, work with EMR, suggest practices have these projects to try to encourage this type of coordination.

III. Discussion:
a. Feel missing is patient component. I don't see any other reform suggested than copay containment. More and more patients are becoming aware of choices that can be made. Feel it needs to be mentioned.
b. Paul Block – Sperian model
c. Incentives, medication incentives, adherence. There was a study in which people were given cardiac medications free to monitor adherence, and at that point, the adherence measure was still low. If free doesn't move alone, its not helpful. There needs to be incentive programs that promote
d. Group out there right now that is working on the issue of patient education and compliance with pharmaceuticals. The other incentive is when plans go up as quickly as they are, pretty good financial incentives to get their
e. Paul Block, over 20 years ago had an incentive program for alcohol program at the VA. After a few sessions no one attended. There gave

monetary incentives to attend or give cancellations. Attendance did not increase.

f. Confused about the ramping up of the communication without a linkage to the patient. Recognize this is a relatively new environment, and this may be a rocky start. What are the efforts made to garner the patients ear, and perhaps consolidate one location. When talk about other stakeholders also coordinated with patients it gets more challenging, but through individual insurers should have
g. It isn't just individuals, it is those who receive reminders for all those dependents.
h. What do we do with the information that has been presented in this committee. A lot of it has different names, but they are aimed at similar goals. We have a whole community out there that doesn't know what we all know about payment reform in RI. Also I think as these programs that we all need in RI , is it reducing cost, are providers making out in some way as well as the patient so all are benefiting. Aware that there is this background that the exchange may be a catch all.
    i. Three branches on this going forward: Dan is working on a report that flows from all of the sessions you have had in this group, looking at all payers and providers, what levels of maturity are these various efforts. At the executive committee of the health care reform commission today, we will focus on the CMMI efforts, and today the Lt. Governor will be convening a group across the leadership team to see where we would like to go w a state request. Essentially it would be around the idea of a continuum of reform. Third strand is the Lt. Governor has charged this group to go back again and review legislation that has come out in other states recently and see what is relevant to RI or the interest of this group going forward.
i. We really need to put stakes in the ground and put some sort of time frame out there, enabling folks to work backwards. The part we have not discussed is the transition period. The thought that we can suddenly jump is not realistic – need to focus on a manageable transition period.
    i. Agree excellent point. Some of the CSI practices as well as at coastal now have contracts where the total cost of care matters for Coastal. Working with hospital systems that are still on a volume and margin model, which show those two opposed to each other. Feel this is at the center of the challenge today.
        1. New flow of information, not metrics used to seeing. Start to flow that information – what about the small groups. Keep them in mind.
    ii. Some of the discussion about shared revenue savings have been raised, and a general level of awareness raised in this group, and what the tools are and general pathways are.

Getting to a broader awareness is part of the challenge fort his group. The three areas for action discussed above will aide in that. Really having some thinking in this room in the broader decision group about how to move it forward. What approaches do we want to see in this state, what are the various arrangements already underway, how can we expand those to make a case to the feds for innovation funding.

j. Need to look back to the earlier concern about the multiple messages coming to patients and the multiple messages coming to providers. The communication piece is key. Concerned about how we would have the success and how we would have the key for the patient to make sure we have the messages key and supportive.
k. Don't believe we will reinvent the wheel here, these are things happening nationally, the problem is that we tend to have the same people involved – the leaders in the stakeholder communities. The concern that appears is there is a good about of engagement of the leadership, but fear the rank and file members of the organizations, particularly the doctors, don't know what is coming down the road. Unless they are engaged and educated on these sessions, its an enormously steep hill to climb.
    i. SD: Getting docs to look up from their practice, or to engage in efforts going on is a major challenge. There are some things that the AMA is coming out with in the next few weeks to begin the engagement process. Expand CSI, expand efforts, but partner with the providers.
    ii. JW: Agree with your points, but then in addition need to think of the patient engagement as well. How can we move them forward together.
l. Thorny issues, like what to do with small groups. Created in MA a massive IPA, and you can imagine what the results were as just dropped in to a large group. Not just education,. What to do with hospital fixed costs in an era of declining volume. Small group issue in RI , the small groups pass through that period, 82% of that population are on health mate. Cannot get into a PCMH unless on a product.
m. Having worked in MA BCBS for years, the most important thing providers is viewing that they insure the patient instead of the provider. The physician is very concerned about outlier, so what we really need is to move the insurance company away from insuring the patient to insuring the provider. RIGA was a capitation model – but if RIGA had been able to move its capitation model. Need to do a better job with local papers, get them to understand. If communicate with the people work with it through the people.
n. Wer are on the cusp of a season when oceans of money will be spent immunizing hundreds of things, health care included. If we don't have some sort of measure to work with that.

o. If want to engage people, getting them to respond to small incentives, is it worth the effort the way that we put into it, then asking us to be at risk is even farther away from that. If there is an incentive, something really achievable, really understandable that they can do tomorrow.
p. There is a statistical challenge with dealing with small practices. Random variation will drown the effects of real intervention in small populations. If going to focus providers on utilization, to have a practice big enough to have 5K Medicare patients is a pretty large practice. One more issue to keep in mind.

IV. Adjourn – Next Meeting Feb 27, 2012 8:00am